



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TEXAS HEALTH OF FORT WORTH  
3255 WEST PIONEER PARKWAY  
ARLINGTON TX 76013

#### **Respondent Name**

EMPLOYERS ASSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 34

#### **MFDR Tracking Number**

M4-12-1795-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "HRA has been hired by Texas Health of Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008. Per the applicable Texas fee schedule the correct allowable would be per the DRG 493. The allowable for this DRG per Medicare is \$11,328.83, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at \$16,629.23. Based on their payment of \$16,378.23, there is an additional of \$251.00, still due at this time."

**Amount in Dispute:** \$251.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Coventry, the carrier's bill review audit company, reviewed the MFDR request...Coventry has determined the bill was audited correctly."

**Response Submitted by:** Employers, P. O. Box 71088, Charlotte, NC 28272-1088

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2011 To April 25, 2011	Inpatient Hospital Surgical Services	\$251.00	\$251.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
  - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 21, 2011

  - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
  - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)  
Payment of \$0.00 was previously issued for this claim. The payment should have been \$16378.23. (Z989)
  - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice). (U301)

Explanation of benefits dated January 5, 2012

  - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
  - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

### **Issues**

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 493 is \$11,628.83. This amount multiplied by 143% is \$16,629.23. The total maximum allowable reimbursement (MAR) is therefore \$16,629.23. The respondent previously paid \$16,378.23, therefore an additional amount of \$251.00 is recommended for payment.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$251.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$251.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	March 16, 2012 Date
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## **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**